

IDAHO ORAL HEALTH SUMMIT 2001

Shaping the Future, Improving Access

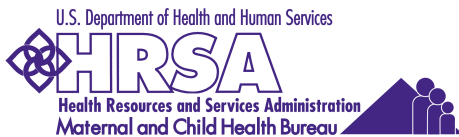
November 16, 2001
Centre on the Grove, Boise, Idaho

SUMMIT REPORT



Convened by the
Idaho Oral Health Alliance

With support from



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SUMMIT PURPOSE AND OVERVIEW

The **Idaho Oral Health Summit 2001** was held in Boise, Idaho on November 16, 2001.

The **purpose of the Summit** was to improve access to dental services for Idaho children and families by creating a shared vision for action among public and private stakeholders.

The Summit brought together 150 dentists, dental hygienists, physicians, nurses, educators and representatives from private and public agencies. Participants looked at the oral health access issues confronting Idaho and identified potential solutions in the areas of policy and funding, access to care, and prevention/education.

The Summit sought to initiate joint planning and problem solving for both short-term and long-term strategies to increase access to primary dental care, reduce disease and improve oral health. Proposed Summit outcomes include:

- State policy recommendations to increase access;
- Creation of a comprehensive state dental public health plan;
- Increased support and funding for dental public health programs and clinics.

The Summit was **convened by the Idaho Oral Health Alliance**. The Alliance was formed in 1998 and is dedicated to improving the general health of Idahoans by promoting oral health and increasing access to preventive and restorative dental services. Members include representatives of State and District Health Departments, private and public health insurers, dentist and dental hygienist associations, medical, nursing and health professional organizations, education programs and others.

Summit follow-up activities will be driven by the strategies proposed at the Summit. Responsibility for follow-up will be shared by stakeholders and coordinated by Idaho Oral Health Alliance members. The Oral Health Program, Idaho Department of Health and Welfare, will provide administrative support.

Funding for the Summit and follow-up is from the Federal Title V Maternal and Child Health Block Grant and special grants from the Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau and Region X Seattle Field Office. Regence Blue Shield of Idaho provided the funding for use of the Boise Centre on the Grove.

MAKING ORAL HEALTH A PRIORITY: CALL TO ACTION

Karl B. Kurtz, Director, Idaho Department of Health and Welfare

“We have to develop a plan of action we all buy into that is focused to not only improve the oral health care of Idahoans, but their overall health and well-being.”

While the oral health of America and Idaho has improved over the last decade, we see a subset of our population with a growing concentration of dental disease. These are the poor: poor children, poor adults, poor senior citizens. Thirty-two percent of Idaho third graders attending lower income schools have untreated cavities compared to 15 percent at the highest income schools. Of these 32 percent, 12 percent have urgent care needs; they have infection and pain. Oral health has taken a back seat to other health issues. We do not have a strong organized constituency lobbying for good oral health care. The general public does not understand the important link between oral health and general well being. Declining numbers of dentists and low Medicaid dental reimbursement rates further magnify the problem. In Idaho, 32 of our 44 counties are designated as either a geographic or population group Dental Health Professional Shortage Area. The toll-free Idaho CareLine averages 500 calls per month from persons seeking a Medicaid dentist. Currently only 70 dentists statewide are accepting new Medicaid patients. There are no easy solutions to the lack of access to dental care by low-income Idahoans. Each Summit participant holds a piece of the puzzle, a portion of the answer, for providing better access.

Jack Riggs, M.D., Lieutenant Governor of Idaho

“In Idaho we need to do better. I have seen the tremendous will and spirit of the people of Idaho, and with all of us working together, we will do better.”

The fundamental problem is that the oral health message is not getting out and to the right audiences: the general public, stakeholders, elected and appointed officials. Our health care system is segregated. Physicians do not fully understand and appreciate the connection between oral health and medical health: the mouth is seen as the dentist’s realm. Potential advocates are disengaged because they aren’t informed. Tooth decay is 5 times more common than asthma, 7 times more common than hay fever. Eighteen percent of children age 2-4 years have experienced tooth decay; only 25 percent of 8 year olds have had a sealant. Each year, 50 million hours of school time are lost due to poor dental health. Children from families who cannot afford access to dental care are 12 times as likely to miss school compared to those who do have access. The implications for early brain development and scholastic performance are staggering. The links between maternal oral health and birth outcomes further illustrate the important link between good oral health and overall health and well being. America and Idaho received a C- on the report card for oral health status and addressing oral health needs. These grades are simply not good enough. Lt. Governor Riggs stressed three points for improving the oral health of Idahoans. First, he recommended getting the public more engaged in the issue by increasing awareness and education. Second, he said everyone must increase their activity with the legislature and state government, coming forward as individuals rather than representing groups or agencies. And last, he implored the group to be more creative in thinking outside the box and taking action to solve the problem.

STRATEGIES TO IMPROVE ORAL HEALTH

Summit participants divided into three groups for facilitated discussion focused in one of the following areas: Policy and Funding, Access to Care and Education/Prevention.

The purpose of each breakout session was: 1) to brainstorm ideas and solutions, and 2) to identify strategies to develop and implement these ideas and solutions. The Surgeon General's Framework for Action as outlined below was presented as a reference point for developing these ideas, solutions and strategies:

- " Change Perceptions of Oral Health
- " Build Effective Health Infrastructure
- " Remove Barriers to Oral Health Services
- " Accelerate Building and Application of Science

Breakout group participants were asked to consider the following in proposing solutions:

- " Desired Outcomes: What will be done/accomplished with this idea or solution?
- " Process: What strategies/actions are needed to accomplish the desired outcome?
- " Challenges: What factors could impact carrying the idea or solution forward?
- " Who: Who are the individuals and organizations who must be involved to successfully move the idea forward?
- " Next Steps: What are the next steps and the time frame for moving the idea(s) forward?
- " Future Involvement: Who in the breakout group is willing to be involved following the Summit to help move these solutions and strategies forward?

On the following pages are listed the ideas and potential solutions discussed by each breakout group, as recorded on flip charts by the facilitator and then later transcribed. The facilitator of each group presented a brief summary of these recommendations at the close of the Summit.

Group A: Policy and Funding

- " Establish dialogue and build linkages between the Idaho Medical Association and the Idaho State Dental Association
 - " Education of professionals could translate into support
 - " Diffusion of ownership and change practice programs
 - " Incorporate the participation of:
 - " Hospital association and primary care organizations
 - " Idaho Dental Hygienists' Association
 - " Idaho Nurses Association
 - " Indian Health Services
 - " National Education Association, Idaho Department of Education and Head Start programs
- " Support, enhance or develop a pilot program that incorporates the key components of access, reimbursement and a "home" for oral health care (Terry Reilly Health Services dental clinic replication)
- " Develop recruitment and retention strategies and seek the appropriate legislative and financial support
- " Work with Medicaid to look at other "best health practice models"
 - " Investigate a Medicaid dental "best health practice" model - a policy effort in Arkansas that increased Medicaid reimbursement rates
- " Establish a process in which primary care physicians could bill for dental procedures
- " Maximize use of resources to ensure prompt payment of Medicaid claims
- " Modify the Idaho Dental Practice Act; begin with dialogue first (avoid turf issues and focus on the issue of better oral health)
- " Define dental prevention and determine who could be trained to deliver it
- " At the school-based level (primary, middle and high school) have an individual responsible for implementation of preventive and basic treatment services; assess what is currently working
- " Develop a strategy for dentists to be reimbursed for patient dental health education
 - " Must be worded carefully for the federal government
 - " Follow medical template "face to face consultation" and "disease consultation"
- " Investigate ways to increase access, e.g., pro bono options (need a gatekeeper), mobile vans, new partners, etc.

Group A: Policy and Funding (continued)

- " State loan repayment and scholarship programs
 - " Increase funding
 - " Make access easier
 - " Establish "charitable" values early in graduates and students
 - " Address water fluoridation
 - " Educate the public
 - " Develop State policy
 - " Establish tax breaks, credits or incentives for dental practitioners
 - " Establish oral health outcome measures
 - " Establish a special fund dedicated to children's dental prevention
 - " Enhance oral health grant writing capacity
 - " Partner with Idaho higher learning institutions (technical schools, universities and colleges) and communities to better define oral health problems and develop solutions
 - " Look at dentist Medicaid reimbursement and consider tying the reimbursement to the cost of living or consumer price index
 - " If Medicaid dental reimbursements come in lower than budgeted, divide unspent funds among Medicaid dentists
- Institute a policy for schools with soda pop machines to also offer alternatives such as water (particularly with fluoride), milk and appropriate fruit juices

Group B: Access to Care

" Issues

- " Providers
 - " Capacity
 - " Scope of practice and services
 - " Specialists
 - " Licensing issues
 - " Role of dental hygienists and dental assistants
 - " Replenishing the person power/our base
 - " Where to refer people?
- " Transportation
- " Oral health consumers not intellectually armed with the knowledge that they ought to have to appropriately access and navigate the oral health system (access points, eligibility, programs and services)
- " Reimbursement rates
- " The uninsured and working poor

" Ideas

- " General
 - " Oral health access could be defined as chair time (time in a dentist's chair receiving services)
 - " Need to partner for a better standard of oral health care
 - " Get to people often and early
 - " Good case management
 - " Broad view
 - " Payment plans - offer a sliding fee payment schedule
 - " Emphasis on prevention
 - " Humane access to emergency care for those without a medical or dental home; emergency room should not serve as a medical or dental point of care
- " Expand the function of auxiliary staff
 - " Need to change the laws regarding dental hygienists and dental assistants to allow them to do - appropriately - more than what they currently are doing; under utilization of a resource is a disservice
 - " Conduct a service inventory to learn who is doing what and what is working
 - " Partner with private dental and medical practitioners
 - " Enlist hospitals and health departments as key partners
- " Expansion of education/teaching, training and residency programs
 - " National Health Services Corps SEARCH model (Student Experiences and Rotations in Community Health)
 - " Area Health Education Centers
 - " Private practice dentists and universities

Group B: Access to Care (continued)

- " Our Ideal Dental Health System
 - " Public health departments and hospitals
 - " Faith community
 - " Head Start
 - " Schools
 - " Local philanthropies
 - " United Way
 - " Private
 - " Dentists
 - " Dental hygienists
 - " Dental assistants
 - " Primary care physicians
 - " Pediatricians
 - " Education component for professionals, consumers, policy makers and resource holders
 - " Legislative focus: adequate reimbursement rates
 - " Global enough that the stigma would be reduced: oral health is a key part of overall health
- " Other ideas
 - " ABCD - replicate it
 - " Licensed dental professionals working in medical clinic settings (public or private)
 - " Licensure reciprocity
 - " For new dentists, mandatory pro bono or Medicaid cases
 - " On-going training for non-dental providers geared toward identification and potential treatment of oral health issues as part of treating the entire individual
 - " Resource development to secure funds to shore-up the oral health safety net of services and providers
 - " Increased activity from the dental society; encourage local components and members to think more broadly and engage in collaborative endeavors that will improve oral health
 - " The role of parents in their own oral health care and the role that parents play in their children's oral health care; train parents around good oral health behaviors/habits, maintenance and routine oral health care; WIC is a good model to build on
- " **Implementation Idea: Expanded Functions of Existing Dental Providers**
 - " Desired outcome is improved access to oral health services and improved oral health outcomes (reduced disease and disparities) by increasing capacity of existing resources and developing new capacity to meet the oral health needs of Idaho
 - " Functions
 - " Education
 - " Training

Group B: Access to Care (continued)

- " Diagnosis
- " Treatment
- " Restorative
- " Preventive treatment
 - " Fluoride varnish
 - " Sealants
 - " Parent/patient education
 - " Non-dental and medical components of prevention
 - " Screenings and assessments
- " Prescription or pharmacy capacity (arrangements)
- " Who
 - " Dentists (should have license reciprocity; ability to work in at least two states)
 - " Dental hygienists
 - " Dental assistants
 - " Potentially:
 - " Primary care physicians
 - " Pediatricians
 - " Licensed nurse practitioners
 - " Physicians assistants
 - " Registered nurses
- " How
 - " Lobby/advocate
 - " State Board of Dental Examiners
 - " Key elected and appointed officials and candidates
 - " Partners
 - " Idaho State Dental Association
 - " Idaho Dental Hygienists' Association
 - " Community
 - " Other stakeholders

Group C: Education and Prevention

" Desired Outcome

- " Children will be able to concentrate on learning and be free of dental pain

" Challenges

- " Take quick action
- " Avoid getting bogged down in over collaboration
- " Streamline limitations in the law for dental hygienists and dental assistants
- " Political barriers between dental and medical professionals - turf issues
- " Funding - a limited pool and competing priorities; perception that when general funds are short, dental health loses support
- " Reimbursement barriers
- " Need to fully integrate oral health into comprehensive health care (coordination of service providers)
- " Dental health is not in the State's top five priority maternal and child health issues
- " Time, patience and long-term commitments are required for making the changes needed to improve oral health in Idaho
- " Evidence shows that increasing the scope of practice will expand hygienist's longevity in the workforce and increase the efficiency of a dental office

" Ideas and Opportunities

- " Dental health written into school curriculum
 - " Remove soda pop and candy machines from schools
 - " Educate school boards on importance so it will be written into standards
 - " Strategy at the local level
 - " Investigate current standards related to oral health (in Idaho and across the United States)
 - " Allow dental hygienists to teach in the classroom
 - " Grant development - provide materials to teach
- " Include oral health care as a standard component of maternal prenatal care and integrate with well-child baby care (include oral health screening/risk assessment and early childhood tooth decay prevention)
 - " Help parents to be responsible for their own dental health and the dental health of their children
 - " Provide fluoride varnish to WIC, Head Start and Early Head Start children
 - " Medicaid and private insurance reimbursement for chlorhexidine rinse and xylitol gum; increase Medicaid reimbursement for preventive dental services
 - " Make mandatory under Medicaid: attend prenatal classes; include oral health component
 - " Increase Medicaid reimbursement for pregnant women who need to get their teeth cleaned; expand Medicaid benefits to include periodontal and restorative services for one year after delivery
 - " Dental professionals train medical professionals to identify, refer for treat oral health needs, apply fluoride varnish (physicians, nurses, administrative staff)
 - " Identify physicians who will take a leadership role and support the training
 - " Work with state level associations

Group C: Education and Prevention (continued)

- " Fluoridate Idaho community water systems in areas where 80% of population does not have optimum fluoride in the drinking water; target three areas over the next 36 months: Bannock County, Bonneville County, Farmway Village in Canyon County
 - " Work with the Centers for Disease Control and Prevention
 - " Conduct a cost/benefit analysis
 - " Conduct a public information campaign to build support
 - " Work with DEQ and public water system operators
 - " Involve Delta Dental Plan of Idaho
 - " Involve the medical community and identify someone to take the lead (remove the resistance)
 - " Determine the approach to effect outcomes by community
 - " Mandate as a last resort
- " Fully funded preventive dental public health program in all seven health districts, coordinated by a full time dental hygienist
 - " Lobby for a legislative initiative (policy and funding)
 - " Assess grant opportunities that do not limit options and resources
 - " Approach the Health and Welfare Committee and determine how the IOHA could better inform, help make policy and policy decisions
 - " Find and develop supportive data to help make the case to place oral health higher on the list of legislative priorities
 - " Integrate dental hygienists into the local dental societies
- " Parents assisted in being responsible for their own dental health and the dental health of their children
 - " Media/public awareness campaign (general and customized for any and all socioeconomic and cultural groups)
 - " Educational programs:
 - " How to be a good dental care consumer
 - " Impact of oral health on general well-being, including prenatal care
 - " Rewards/incentives for keeping appointments
 - " Coordinate with Health Care for the Homeless
 - " Involve school nurses
 - " Focus on prevention
- " Increase school-based sealant programs
 - " Provide sealant and fluoride varnish early and often
 - " Utilize portable equipment and mobile dental vans
 - " Children should be pain free
- " **How do we move this forward?**
 - " Keep the process simple; collaborations can get cumbersome and unrealistic; keep the process manageable and pragmatic
 - " Dentists and hygienists get together to address expanded functions
 - " Develop a plan so potential partners can determine how to be involved, and their appropriate role and contribution

Group C: Education and Prevention (continued)

- " Share today's outcomes and learning with oral health constituents, providers and other stakeholders (primary care physicians, etc.)
- " Call our legislators

- " The following individuals are interested in continued involvement regarding prevention and education strategies:
 - " Lisa Penny, Idaho Department of Health and Welfare
 - " Lalani Ratnayake, Central District Health Department
 - " Roxanne Joyner, Delta Dental Plan of Idaho
 - " Tina Fisher, Terry Reilly Health Services
 - " Kathy Tuller, President, Idaho Dental Hygienists' Association

PRE-SUMMIT INTERVIEWS

Pre-summit telephone interviews were conducted with government, business and community leaders, and included some members of the Idaho Oral Health Alliance. Results of these interviews reflect, reinforce and validate the discussion of the Summit presenters, panelists and breakout groups. The over-arching theme from both the pre-summit telephone interviews and the November 16 Summit was that it is time to "raise the bar" regarding oral health in Idaho. The interview comments consistently fell within one of the three Summit focus areas: Policy and Funding; Prevention and Education; Access to Care. All of the persons interviewed were asked to share their perspective on the following:

- " the most pressing oral health issues impacting Idaho
- " oral health strategies that are making a difference
- " ideas to improve oral health and access to care
- " "tips" for the November Summit

Following is a sampling by category of the pre-summit interview responses.

Priority Oral Health Issues

- " Cost of dental care
- " Lack of access to care for low-income, no income and Medicaid clients, especially children, elderly, the disabled
 - " Lack of Medicaid dental providers
 - " Low Medicaid reimbursement rates that don't cover dentists' overhead and billing issues
 - " Perceptions about Medicaid population and associated stigma
 - " Low dental IQ and need to educate Medicaid clients about how to be responsible consumers/good patients
- " No one advocating for children
 - " Children, particularly those who are low income, are suffering with untreated, preventable disease
 - " State should provide health coverage for all children
 - " Dentists not seeing children ages 0-2 for examinations
- " Weak dental public health system
 - " Limited funding
 - " Low public health salaries compared to private practice
 - " Lack of a central coordinating office
 - " Disjointed and fragmented oral health care system
- " Dental manpower issues
 - " Maldistribution of dentists, declining number of graduates, aging workforce
 - " Under utilization of dental hygienists and limits of Idaho Dental Practice Act
 - " Lack of dental specialists; e.g. pediatric dentists

Pre-Summit Interviews (continued)

- " Dental perceptions of public, health professionals and policy makers
 - " Do not recognize the connection between medical and dental health and the individual and societal consequences of dental disease
 - " Don't value oral health
 - " People don't like to go to the dentist
- " Lack of community water fluoridation

Oral Health Strategies that Work

- " District Health Department preventive dental programs
 - " Full time public health dental hygienists employed in each district (funding was cut; now are part-time)
 - " Preventive clinics staffed by dental hygienists
 - " Fluoride varnish programs to prevent early childhood caries (ECC)
 - " Preventive dental care and referral for pregnant women
 - " Community outreach/social marketing
 - " Continuing education for dental, medical and other health professionals
 - " School-based fluoride mouthrinse and dental sealant programs
 - " Classroom education programs for students
- " Washington ABCD Medicaid Program and "Watch Your Mouth" Campaign
- " Head Start dental program
 - " oral screening, referral and funding for follow-up care
 - " long-term goal is to work with pediatricians to get them to look for caries during well-child exams
- " Community Health Center dental clinics, e.g., TRHS Boise Dental Clinic
- " Private dental practices where one-third of patient mix is Medicaid; these practices have good patient management policies
- " Rural Health Care Access Program
 - " Provides grants to communities and organizations to help recruit and retain providers
 - " Medical focus; would like to expand focus to include dental
- " Columbia Dental, the first dental managed care in Idaho
 - " long-term approach to patients
 - " focus on prevention
- " Regence Blue Shield of Idaho Caring Foundation
- " Use of dental residents to provide services, e.g., the Idaho Advanced General Dentistry Program in Pocatello

Pre-Summit Interviews (continued)

Ideas to Improve Oral Health and Access to Care

Suggestions for improving oral health and access were closely aligned with the "priority issues" and "strategies that work."

- " Medicaid policy and reimbursement changes
- " Increased funding
- " Strengthening the dental public health infrastructure
- " Expanded use of dental hygienists
- " Recruitment and retention of dentists
- " Incentives, such as tax relief and loan forgiveness
- " Changing perceptions about oral health among public, health professionals and policy makers
- " Water fluoridation
- " Establishing community-based and school-based dental clinics
- " Dental residency programs
- " Collaboration and volunteerism
- " Legislation and grassroots advocacy

Respondents identified a broad spectrum of desired outcomes related to development and implementation of collaborative strategies that will improve health and access to dental care. Among these were development of a state dental health plan and formation of a Governor's Oral Health Task Force to guide the effort. Respondents were unanimous in wanting to see concrete results as a result of the Summit and follow-up.

SUMMARY OF PARTICIPANT EVALUATIONS

Key Conclusions from Participant Input

- 1) Summit was well received and very successful for learning, networking, sharing information and providing issue clarification. Some uncertainty was expressed regarding how/if future progress will be made in fulfilling the Summit purpose of a shared vision. Most people seemed to think that, while there is much work to be done, a great start has been made.
- 2) Participants are very interested in receiving a copy of the meeting record, particularly the content of the participant input and breakout sessions. Making this information available will be an important part of keeping the effort moving.
- 3) Follow through and ongoing status reports are essential for continued support of goals and actions and for involvement with future summits.
- 4) Future summits should continue focus on presentations from a wide range of stakeholders. They should also provide increased opportunity for networking and for small(er) group discussions with topics that are more specific.

Summary Comments by Question

Question #1: Respondents by profession/segment of the Idaho population

87 participants completed the evaluations.
Dentists – 11 Dental Hygienists – 22
Dental Education – 7 Dental Assistants – 4
Dentistry – 7 Public Health – 14
Insurance – 13 Other – 9
(Medicaid – 12; Carrier – 1)

Question #2: Was information helpful?

Almost unanimous “yes”

Question #3: Achieved purpose of creating a shared vision?

Responses ranged from “awesome”, with statements about having a real sense of progress made, to other statements indicating there is still a lot of work to do. (Summit created more questions; the information was not concise enough yet; it is difficult to achieve a shared vision with this size group; more work is needed before we have a finished product.)

Question #4: What liked best?

The panel received the most consensus for “the best”. Also included: opportunities to jointly discuss issues and to network; value of diverse attendees. Dr. Milgrom was mentioned a few times, as was Lt. Governor Jack Riggs. The facilitated process was helpful.

Question #5: Suggestions for improvement?

The most common responses indicated a need for more time for discussions and networking. Several also indicated a need for greater involvement by more dentists, legislators and health professionals.

Question #6: Satisfaction with process for gathering information?

Mostly very satisfied with the process.

Question #7: Satisfaction with the quality of information gathered and the outcomes?

Mostly satisfied with the content.

Question #8: Should the Summit be held on a regular basis? How often?

Almost unanimous “yes” for holding the Summit on a regular basis.

Most said annually. Several said every six months. Others indicated every 2-3 years.

Question #9: Would you attend a future Summit?

Almost unanimous “yes”. A few indicated the qualifier, “if we continue to make progress”.

Question #10: Other comments?

Ranged all over and generally reflected the same information covered in the first nine questions. These comments reinforced: the need for legislative change and involvement; compliments to organizers and meeting location; need for further action and follow through.

The only criticism in the evaluations, that had any consistency/repetition, was the perception of a few that the facilitators/“mediators” were biased. However, at least an equal number of comments were favorable to the quality of facilitators and the facilitated process.

Appendix